Welcoming in primary health care from the viewpoint of nurses

Acolhimento na atenção primária à saúde na ótica de enfermeiros

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Keywords
User embracement; Primary care; Primary care nursing; Public health nursing

Descritores
Acolhimento; Atenção básica; Enfermagem de atenção primária; Enfermagem em saúde pública

Submitted
June 13, 2016

Accepted
August 29, 2016

Abstract

Objective: To understand how the welcoming process occurs in the basic health units from the viewpoint of nurses.

Methods: An exploratory study with a qualitative approach that used semi-structured interviews, and adopted the content analysis technique proposed by Bardin for data analysis.

Results: Among the ten interviewed, nine were female. Analysis of the statements led to the emergence of access and the work process as empirical categories.

Conclusion: Welcoming is performed in the Basic Health Units of a Regional Federal District, but not in a structured manner, nor is it grounded in the recommendations of the Ministry of Health.

Resumo

Objetivo: Compreender como ocorre o processo de acolhimento em unidades básicas de saúde na ótica de enfermeiros.

Métodos: Foram utilizadas entrevistas semiestruturadas, e para análise dos dados adotou-se a técnica de Análise de Conteúdo proposta por *Bardin*. Para tal foi realizado um estudo exploratório de abordagem qualitativa.

Resultados: Dos dez entrevistados, nove eram do sexo feminino. A partir da análise das falas emergiram como categorias empíricas o acesso e o processo de trabalho.

Conclusão: Conclui-se que o Acolhimento é realizado nas Unidades Básicas de Saúde de uma Regional do Distrito Federal, mas não de forma estruturada nem embasada no que está preconizado pelo Ministério da Saúde.

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DOI
http://dx.doi.org/10.1590/1982-0194201600063

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Conflicts of interest: there are no conflicts of interest to declare.

Introduction

The directive of welcoming was introduced into the Unified Health System (SUS) services in the mid 1990s, aiming, enabling changes in the development of health work by modifying relationships between workers, managers and patients, promoting linkages, co-responsibility and resolution, in addition to expanding access.[1] However, the debate about welcoming has intensified since 2000, as a proposal for reversing the logic of the health service organization and functioning, in order to assume its original mission, which is to welcome, listen to and provide a positive response, being able to solve the population's health problems.[1]

With regard to the labor process, the welcoming guideline aims to shift the central axis from the physician to a multidisciplinary team, which is in charge for qualified individual listening, committed to solving the health problem and to transform the relationship between worker and patient, based on humanitarian parameters, solidarity and citizenship. This feature relates to the current discussions that have been occurring on the social construction of Primary Health Care (PHC-APS), attempting to break with some prevailing conventional paradigms, such as the adoption of a health management model for the population, rather than a supply management model. [2]

For the Ministry of Health, there are several definitions of welcoming, which reveals the multiple meanings for this term. Also according to this agency, less is revealed about welcoming in the speech about it than in the concrete practices. In this sense, instead of (or in addition to) asking whether, in the particular service, welcoming occurs or not, it would be more appropriate to analyze how it works.[3] Thus, this study aimed to understand the process of welcoming in the Regional Health Basic Health Units (UBS) of the Federal District, from the perception of nurses.

The expected purpose of this study is to contribute to the discussions about the organization of PHC in the Regional Health, particularly with regard to welcoming.

Methods

This was an exploratory study with a qualitative approach, conducted in ten of the 11 UBS, existing in the region. The criteria adopted for selection of units was based on those in which welcoming was integrated. Nurses that performed the act of welcoming were invited to participate in the study, regardless of the length of time that it had been integrated into the unit.

The empirical data collection was performed from April to July of 2014, by means of individual semi-structured interviews in a private environment at the UBS itself, using the following question: Can you tell me how welcoming was applied here in the UBS, and how it works ? Each interview was encoded using the Subject name followed by Arabic numerals 1, 2, 3, 4, 5, 6, 7, 8, 9, 10.

After agreement, the professional signed the Terms of Free and Informed Consent, and the interview was conducted, recorded, and later transcribed, maintaining the literal content of the statements. During data analysis, the adopted technique of content analysis proposed by Bardin[4] was applied.

The study was registered in *Plataforma Brasil* under *Certificado de Apresentação para Apreciação Ética* number (CAAE): 25086814.0.0000.555.

Results

Ten nurses who were responsible for welcoming participated in the interviews, one from each UBS. There was a predominance of females (nine nurses), with ages ranging from 26 - 61 years; mean training time of 12 years and six months, ranging from 3 - 33 years; with a mean of three years and one month working on the unit, ranging from 3 months - <14 years; and mean time of working with welcoming of three years and four months, ranging from 2 months - <14 years.

By analyzing all the statements of the professionals, it was verified that welcoming is closely linked to the organizational manner of the local network services, involving human, physical and environmental resources. In this sense, the access and work process was established as empirical categories, as chart 1.

Chart 1. Empirical categories and the statements of nurses

Patient access to the health services
"[...] patients arrive here in the morning, because there are a limited number of vacancies, they need to get a space in this queue. So, 5am, patients are arriving. There's the risk of violence, there are elderly patients who cannot leave at this time, there are a lot inconveniences for the patient in this way [...]" (Subject 3)
"[...] if the welcoming work, if we had a structure for it[...] welcoming would be the moment that when he needed it, he would come here [...] without having to stand in line in the early morning." (Subject 5)
"[...] where he arrives, where he is cared for, he is going to be welcomed, regardless of whether there is a specific location that he has to go to or not ."(Subject 2)
"[...] he usually arrives at the entrance, has a complaint, does not have a scheduled consultation [...]"(Subject 6)
"[...] then the individual route will vary according to his needs when he comes to you [...]" (Subject 7)
"Our door is freely open, if you knock on it, it is answered." (Subject 10)
Working process of nurses working in welcoming
"The nurse's role is more like guiding, promoting health. Resolution of that patient's problem, directing him, to where he will go, checking to see if he is going to the physician. It is trying to help that patient, caring for the health problem that he has at that time." (Subject 11)
"[...] we already understand that is not a room. It's all a service focused on welcoming." (Subject 2)
"Then I receive them, I welcome them; they can talk, they are received into the room, they are humanely treated, and some nursing needs are recognized by me during that contact. It means that they receive a nursing consultation and some of their questions can be resolved in that first contact." (Subject 3)
"Within the basic unit here in the center ... there is no risk classification. It's the same thing with the welcoming, there is no protocol, we don't follow a risk classification protocol, we do not have one, it doesn't exist." (Subject 7)
"I do not know what to tell you, if we stopped to ask about welcoming in the center, what people would say you. I do not know if it would work very well. We perform the welcoming. But I cannot tell you if they know it."(Subject 7)
"[...]I think it was already clear in all my statements the perception that it gives a qualitative difference to the work, it's huge, it is clear." (Subject 2)
"I see many benefits with regard to welcoming, [...] the question of organization, also the question of welcoming, not only with respect to the individual, but in relation to the team. Because when an awareness of the work occurs, we understand welcoming. Even the interpersonal relationships change, it is different." (Subject 5)
"the primary component of welcoming is active listening, to hear and determine whether he needs care, a physician, a nurse, if sometimes he is searching for something that is not from our unit, that is for a specialty." (Subject 6)
"welcoming, we do it more or less, we do not have it very structured, but we do it more or less within the risk classification. There is very little literature on welcoming in primary care. There, care is prioritized by risk, by the health of the patient. We developed a protocol where there are criteria, but it is not a protocol of the unit [...] There is no formalized flow, we do it according to need." (Subject 9)

Discussion

The National Primary Care Policy (PNAB), published in 2006, has among the characteristics of the primary care team working process, the implementation of the guidelines of the National Humanization Policy, including welcoming.[5]

In revising the PNAB, Ordinance No. 2488 of October 21, 2011, welcoming remains as a feature of the team work process and is recommended to be performed with active listening, risk classification and a multidisciplinary room for welcoming for those with spontaneous demands, with health needs assessment, and vulnerability analysis in view of the responsibility of providing care and the first emergency attendance.[6]

Approaching the concept of welcoming in the health practice, we can understand that it is a tool that enables a guaranteed access in solidarity with the individual in the health service.[7] It can be used as an interrogator device of daily practices, allowing you to capture noise in the relationships established between individuals and workers in order to change them, establishing a working process centered on the individual's interest. Thus, welcoming constitutes a technology for the reorganization of services, with a view to guaranteeing universal access, resolution and humanization of care.[8]

Based on this study it was noted that health work in the traditional manner still prevails, focused on medical consultation, by distributing tickets for spontaneous demand. Thus, many individuals still leave the health unit without having their problem resolved. Therefore, in these cases, the proposal of welcoming was not covered, since it establishes a fixed number of vacancies, and does not meet the needs of the population. It is important to note that not all individuals served in the UBS need health care, but they believe that only a professional will resolve their needs. Therefore, the importance of welcoming is that you can guide and direct individuals to care that is appropriate for their needs.

However, the nurses' statements showed attempts to alleviate this problem with proposals for local reorganization, aiming to reverse the logic of caring for those who come first to those with the most need. Thus, welcoming was pres-

ent in the statements of the subjects 2, 6, and 11, as a strategy to enable the linkage between the health worker and the patient, with an opening dialogue, emphasizing the commitment and the bond, and thereby maintaining the principles of universality, completeness and equity of SUS. These findings converge with the study results obtained,[9] by indicating that welcoming and connection between the patient and the professional allow the whole health system to work in coordination, increasing access and improving the work process in health.

Welcoming proposes to reverse the logic of organizing and functioning of the health services, based on the following principles: serving all people who are seeking health services, ensuring universal access; reorganize the work process by moving its central axis from the physician to a multidisciplinary team, and qualify the worker-patient relationship with humanitarian parameters of solidarity and citizenship.[10]

Welcoming should be seen, therefore, as a powerful device to meet the requirement of access, providing connection between staff and population, worker and patient, questioning the process of work, initiating comprehensive care and modifying the clinic. Thus, it is essential to qualify the staff for receiving, caring, listening to, dialoguing, decision-making, supporting, guiding and negotiating.

Starfield[11] discusses access and accessibility and shows that, although they are used ambiguously, they have complementary meanings.Accessibility enables people to reach the services, and access enables skillful use of services to achieve the best possible results. It would be the way the person experiences the health service. The access to the possibility of implementing care, according to needs, has an interrelationship with resolvability and extrapolates the geographical dimension, covering aspects of economic, cultural and functional supply services.[10]

A reality that remains very experienced in other states, and not only in the Federal District, is that access to consultation occurs by order of arrival, with bureaucratic criteria, without prioritizing risks, where welcoming is not part of the agenda. The limitations to access showed patient queues and dissatisfaction, as evidenced in the statement of Subject 3, in that part of the needs of the population cannot be satisfied. Similarly, in the large cities, patients are exposed to common risks, causing feelings of fear and embarrassment, as they need to find ways to ensure compliance, undergoing long waiting times in queues, exposed to all kinds of situations.[10]

The primary care teams have the ability to link, take responsibility, and to act in performing collective actions of promotion and prevention in the territory, individual and family care, as well as the co-management of individual therapeutic projects of individuals, which sometimes requires paths, trajectories, and care lines that permeate other types of services to meet the full range of health needs.[2] The statement of Subject 11 shows the unique role of welcoming, management and maintenance of these relationships.

The nurses of the health units expressed the need to adapt the theory of welcoming into daily practice. The statement of Subjects 7 and 9 demonstrate concern about the adherence to the proposal made by the Ministry of Health MH and also a better definition of what this practice of welcoming would be to improve services.[2]

Furthermore, although useful and even necessary in some types of units, having a "reception room" is not enough. It is misleading to restrict the responsibility for the act of welcoming to the receptionists (or any employee, individually) as welcoming should not be reduced to a stage or a specific place, as evidenced in some statements.

The reports indicate a consensus that every UBS employee must perform welcoming, and that the nurse is the key player in this process. The statement of Subjects 7 and 9 showed that they do not realize welcoming with Risk Classification using a protocol or collectively developed instrument. Many professionals stated they were unaware of the existence of Risk Classification within PHC and, in the opinion of one of the interviewees, this should only be administered in hospitals.

Among the ten interviews, only two nurses, Subjects 3 and 6, referred to performing the work process in welcoming, systematically. They report assessing the complaint, assessing vital signs, investigating chronic or recurrent diseases, the use and access to medicines, thus making the necessary referrals. They emphasize that active listening is of primary importance in welcoming, to hear and determine whether one needs care, from a physician or a nurse, and if the patient is looking for care from another unit, such as a specialty. The majority do not use previously established protocols, based on Ministry of Health guidelines, conducting active listening that can address the need of that patient. That is, welcoming is not recognized as a structuring technology for professional practice.

As also shown in another study, the professionals considered welcoming as a technology for expansion of listening and decreasing the fragmentation of care.[12] However, there are still difficulties in the organization of services and assignments of the UBS itself, hindering the realization of welcoming.

Welcoming is present in the UBS - Regional Health, but not in a structured manner, not grounded in what is recommended by the Ministry of Health. The logic of care in the units is predominantly by order of arrival, as evidenced by the statements of the nurses, which demonstrated concerns for the need of the patient to arrive at the basic unit, in the early hours of the morning, standing in line in an attempt to obtain an appointment.

The fact that the study population was only composed of nurses, not incorporating other professionals who also are or should be involved in the welcoming process, is translated as a limitation of this study.

Conclusion

Although the implementation of SUS has advanced in recent years, especially with regard to the care networks where PHC plays a key role, there are still challenges to be overcome, highlighting the difficulties of access of the population to health services. Regarding welcoming, this study indicates that on one side are the patients, seeking care in a resolute manner, and on the other side are the health professionals who fail to respond with the available and recommended work tools and resources, demonstrating that, in Regional Health, the implementation of welcoming is permeated by conflicts and contradictions.

However, it is noteworthy that, for UBS to work with welcoming, which requires caring for patient health needs, among other things, it is necessary that the local health system be organized based on referral and counter referral to ensure comprehensive care. In other words, it is not sufficient for the UBS, or more specifically, professionals to desire to incorporate welcoming in their work process; a networked articulation is required.

Therefore, the results of this study are intended to contribute to the redirection of activities and development/implementation of welcoming in the Regional Health area of this study, so that care is powered by the patient´s well-being. We also emphasize the importance of future research, aimed at other professionals, in addition to patients as direct beneficiaries, which can provide relevant information to support the discussion on welcoming with Risk Classification and Stratification within the PHC environments in the Federal District, as most of the studies use the hospital area as the scenario.

Collaborations

Camelo MS, Lima LR, Volpe CRG, Santos WS and Rehem TCMSB declare that they collaborated in the study design, data interpretation, relevant critical review of the intellectual content, and final approval of the version of the article to be published.

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